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ABSTRACT

Several important developments have evolved in the supervision of cognitive therapists in the past few years. Five such developments are: (1) the conscious structuring of the supervision session to conform to the suggested structure of the therapy session; (2) increased emphasis on quickly and efficiently conceptualizing patients, refining the case formulation, using the conceptualization to plan treatment, and effectively communicating an accurate conceptualization to the patient; (3) emphasis on the importance of therapists using the same tools and techniques they recommend to patients; (4) a method of teaching therapists to plan treatment and identify problems through a series of questions they ask themselves before, during, and after therapy sessions; and (5) the refinement of a model of extramural supervision to train therapists who practice far from training centers. Future directions in the supervision of cognitive therapists include increased focus on the supervisory relationship, the creation of tools to assess the efficacy of supervision, and the development of methods to teach sophisticated cognitive approaches for different Axis I and Axis II disorders. Just as effective therapists flexibly vary their manner and techniques when dealing with patients, effective supervisors also vary their approach with supervisees in order to forge a strong supervisory alliance. (JBJ)

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New Developments in the Supervision of Cognitive Therapists

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Symposium Presented at the American Psychological Association, August 1995:
Supervising Psychotherapy:
New Developments, Advances, and Possibilities

Perris (1994) notes the dearth of literature in the supervision of cognitive psychotherapy, aside from training issues discussed in the context of outcome studies by Shaw and colleagues (Shaw, 1984; Shaw & Wilson-Smith, 1988) and supervision in rational-emotive therapy (Wessler & Ellis, 1980). Perris lists supervision goals (conceptualizing patients, establishing the therapeutic relationship, specifying therapeutic goals, selecting and implementing techniques to achieve these goals, determining whether goals have been met, and dealing with interpersonal reactions during therapy) and describes the approach he and his colleagues use in the supervision of cognitive therapists in Sweden.

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Though as yet unstudied and unpublished, several important developments have evolved in the supervision of cognitive therapists in the past few years. One involves the process and technology of several of the goals listed above: teaching therapists to conceptualize patients more accurately and efficiently and to plan and carry out therapy more effectively. A second development is in different modalities. These innovations will

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be described and possibilities for future directions in the supervision of cognitive therapists will be described.

One refinement in the process of supervision has been the conscious structuring of the supervision session to conform to the suggested structure of the therapy session. In a collaborative manner supervisor and therapist set an agenda, make a "bridge" from the previous supervision session to the current one (recalling important learnings, reactions to and questions about the previous session, reviewing "homework" of the therapist), discussing specific patients and problems, learning new skills in the context of this discussion, generalizing from one case to others, setting new "homework", summarizing the session, and providing feedback to one another. As in therapy, the supervisor varies this format and his supervisory style as appropriate, taking into account the therapist's goals for supervision, learning style, learning preferences, level of evaluation anxiety, etc.

A second development is an increased emphasis on quickly and efficiently conceptualizing patients, refining the case formulation at each session, using the conceptualization to plan treatment, and effectively communicating an accurate conceptualization to the patient. A new tool, the Case Conceptualization Diagram in Figure 1 (J. Beck, 1995), aids therapist and patient in ascertaining the connection of reactions to and meanings of current typical problematic situations to underlying beliefs, compensatory strategies, and developmental events. The diagram allows supervisor and

therapist to identify central problematic beliefs and behaviors, pinpoint areas of intervention, and understand difficulties that arise in the therapy session itself.

A third development is a continuing emphasis on the importance of therapists themselves using the same tools and techniques that they recommend to patients. Supervisors ask therapists to complete such worksheets as the Daily Record of Dysfunctional Thoughts and Activity Schedules (Beck et al, 1979) and Core Belief Worksheets (J.Beck, 1995). In this way therapists encounter firsthand common difficulties in understanding how to do these worksheets and in motivating themselves to use them. An additional benefit is the reduction of anxiety over being supervised when therapists attend to the thoughts, beliefs, and behaviors that hinder their effectiveness as therapists and their openness to supervision.

A fourth development is a method of teaching therapists to plan treatment and identify problems through a series of questions they ask themselves before, during, and after therapy sessions (J. Beck, 1995). These questions help the therapist assess the strength of the therapeutic relationship, the relative focus on key cognitions, the effectiveness of interventions, the advisability of varying therapy according to patient variables, and the validity of the case formulation, in addition to other important facets of therapy. In addition, therapists and supervisors are advised to use the Cognitive Therapy Rating Scale to assess the efficacy of individual therapy sessions.

Fifth, another continuing development is the refinement of a model of extramural supervision to train therapists who practice far from training centers. Therapists in this year-long training program attend several intensive weekend workshops during the course of the year at the Beck Institute for Cognitive Therapy and Research in suburban Philadelphia and are assigned a cognitive therapy supervisor. The supervisor previews in its entirety a tape of a therapy session which the supervisee has conducted in the past week. The supervisor then conducts a one hour supervision session by phone, oriented around the tape and other cognitive therapy issues. An early assessment of this program has found it to be efficacious in training both novice and more experienced cognitive therapists.

Future directions in the supervision of cognitive therapists include increased focus on the supervisory relationship, the creation of tools to assess the efficacy of supervision, and the development of methods to teach increasingly sophisticated cognitive approaches for different Axis I and Axis II disorders.

Cognitive therapy supervisors have found that their effectiveness is enhanced when they take into consideration the therapist's level of expertise, learning style, degree of anxiety, and dysfunctional assumptions related to patients, therapy, and supervision. Just as effective therapists flexibly vary their manner and techniques when dealing with patients, effective supervisors also vary their approach with supervisees in order to forge a strong supervisory alliance.

In the future, supervision will most likely be guided by cognitive therapy supervision manuals which spell out effective techniques, ways to conceptualize problems which arise in supervision, and methods to remediate these problems. As yet undeveloped rating scales and other assessment tools will measure how effective supervisors are in establishing good working relationships with and facilitating progress in their supervisees.

Finally, supervisors will develop more effective methods in teaching therapists the varied treatment approaches for specific disorders and different age levels. The treatment for panic disorder, for example, is different in some critical ways from the treatment of depression. And severe chronic depressives frequently respond differently from first episode milder depressives. In addition, patients who are co-morbid for personality disorders or substance abuse often require specialized techniques. Approaches to children obviously differ from those used with older patients. The challenge to the cognitive therapy supervisor is to devise methods of teaching the necessary variations of treatment to therapists with a broad range of patients.

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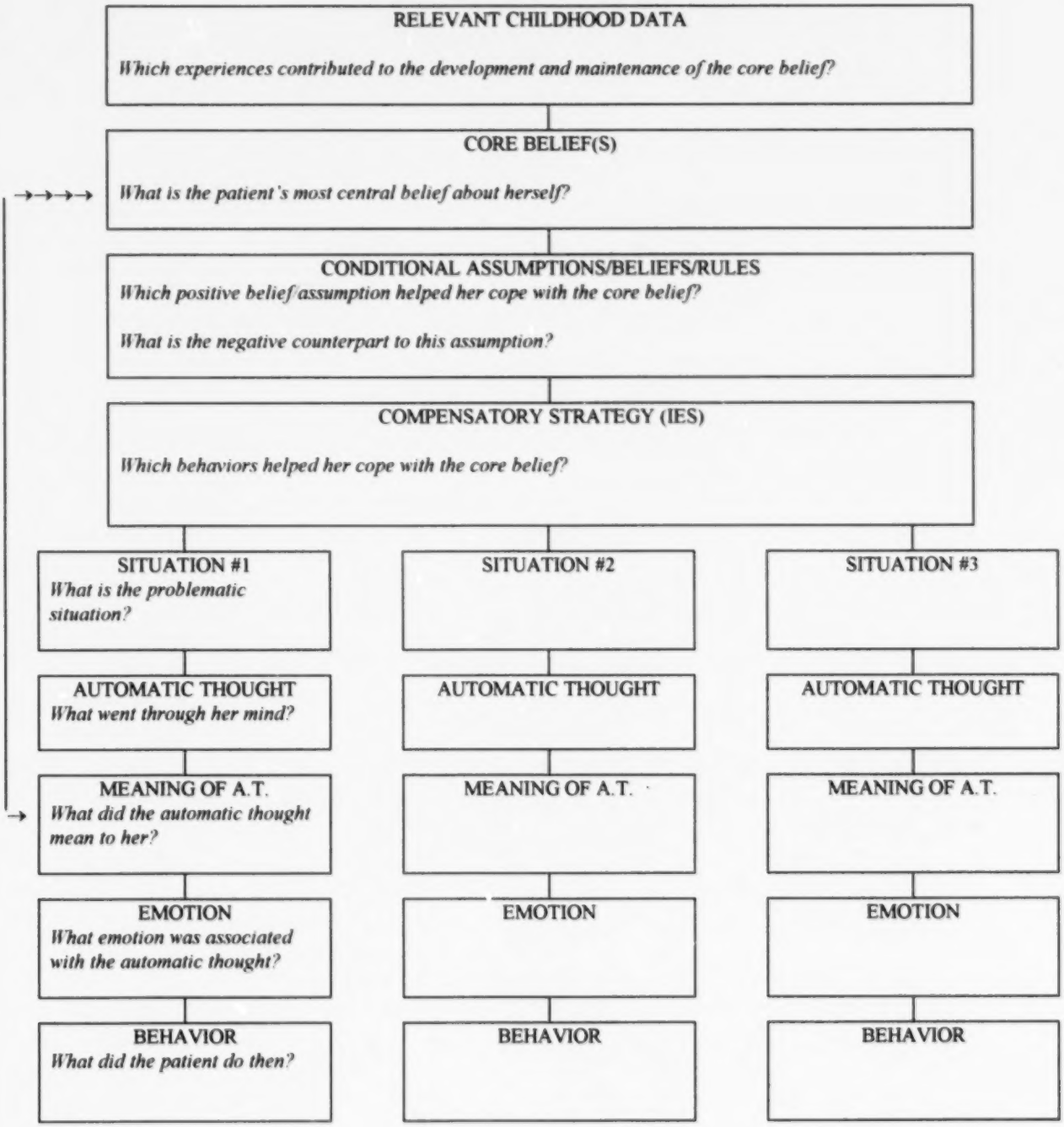
Pt's Initials: Therapist's Name: *Beck Institute*

Pt's Diagnosis: Axis I: Axis II:

COGNITIVE CONCEPTUALIZATION DIAGRAM


RELEVANT CHILDHOOD DATA
Which experiences contributed to the development and maintenance of the core belief?
CORE BELIEF(S)
What is the patient's most central belief about herself?
CONDITIONAL ASSUMPTIONS/BELIEFS/RULES
Which positive belief/assumption helped her cope with the core belief?
What is the negative counterpart to this assumption?
COMPENSATORY STRATEGY (IES)
Which behaviors helped her cope with the core belief?
SITUATION #1
What is the problematic situation?
SITUATION #2
SITUATION #3
AUTOMATIC THOUGHT
What went through her mind?
AUTOMATIC THOUGHT
AUTOMATIC THOUGHT
MEANING OF A.T.
What did the automatic thought mean to her?
MEANING OF A.T.
MEANING OF A.T.
EMOTION
What emotion was associated with the automatic thought?
EMOTION
EMOTION
BEHAVIOR
What did the patient do then?
BEHAVIOR
BEHAVIOR

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